SERFF Tracking Number:	*CCGH-126577402*	*State:*	*Arkansas*
Filing Company:	*Connecticut General Life Insurance Company*	*State Tracking Number:*	*45392*
Company Tracking Number:			
TOI:	*H16G Group Health - Major Medical*	*Sub-TOI:*	*H16G.002A Large Group Only - PPO*
Product Name:	*2010 CSI*		
Project Name/Number:	*/*		

Filing at a Glance

Company: Connecticut General Life Insurance Company

Product Name: 2010 CSI	SERFF Tr Num: CCGH-126577402	State: Arkansas
TOI: H16G Group Health - Major Medical	SERFF Status: Closed-Approved-Closed	State Tr Num: 45392
Sub-TOI: H16G.002A Large Group Only - PPO	Co Tr Num:	State Status: Approved-Closed
Filing Type: Form		Reviewer(s): Rosalind Minor
	Authors: Melissa Pine, Dewey Post, Ilona Barber	Disposition Date: 04/12/2010
	Date Submitted: 04/09/2010	Disposition Status: Approved-Closed
Implementation Date Requested: On Approval		Implementation Date:

State Filing Description:

General Information

Project Name:	Status of Filing in Domicile: Pending
Project Number:	Date Approved in Domicile:
Requested Filing Mode:	Domicile Status Comments:
Explanation for Combination/Other:	Market Type: Group
Submission Type: New Submission	Group Market Size: Large
Overall Rate Impact:	Group Market Type: Employer
Filing Status Changed: 04/12/2010	Explanation for Other Group Market Type:
	State Status Changed: 04/12/2010
Deemer Date:	Created By: Dewey Post
Submitted By: Melissa Pine	Corresponding Filing Tracking Number:

Filing Description:

Connecticut General Life Insurance Company is seeking approval of the following additional plan features to its existing approved group health insurance certificate form series in your state:

Coverage of acupuncture treatment.
Coverage of enteral nutritional formulas.
Clarification of coverage of family planning treatment.
Clarification of in-network and out-of-network claim notification timing standards (180 days in-network and 365 days out-of-network).

SERFF Tracking Number:	*CCGH-126577402*	*State:*	*Arkansas*
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Company Tracking Number:			
TOI:	*H16G Group Health - Major Medical*	*Sub-TOI:*	*H16G.002A Large Group Only - PPO*
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Additional Exclusion text for Medical benefits.
A definition of Average Contracted Rate, identifying a method used to determine charges to be reasonable and customary.
Additional Schedule cost-sharing options for Medical benefits.
A benefit for a 90 day supply for prescription drugs provided by certain retail pharmacies.
Expanded Pharmacy deductible ranges.
Option to limit specialty medications to a 30-day supply, and require coverage at a mail order pharmacy.
Pharmacy Schedules with 3 & 4 Tier options as well as an option for a flat coinsurance benefit.
Several new Pharmacy benefit exclusions.
Definitions for specialty and preventive medications.

Company and Contact

Filing Contact Information

Dewey Post,	dewey.post@cigna.com
900 Cottage Grove Road	860-226-6258 [Phone]
B6LPA	860-226-5400 [FAX]
Hartford, CT 06152	

Filing Company Information

Connecticut General Life Insurance Company	CoCode: 62308	State of Domicile: Connecticut
900 Cottage Grove Road	Group Code: 901	Company Type:
Hartford, CT 06152	Group Name:	State ID Number:
(860) 226-5209 ext. [Phone]	FEIN Number: 06-0303370	

Filing Fees

Fee Required?	Yes
Fee Amount:	$50.00
Retaliatory?	Yes
Fee Explanation:	
Per Company:	No

COMPANY	AMOUNT	DATE PROCESSED	TRANSACTION #
Connecticut General Life Insurance Company	$50.00	04/09/2010	35532775
Connecticut General Life Insurance Company	$750.00	04/12/2010	35559758

SERFF Tracking Number:	*CCGH-126577402*	*State:*	*Arkansas*
Filing Company:	*Connecticut General Life Insurance Company*	*State Tracking Number:*	*45392*
Company Tracking Number:			
TOI:	*H16G Group Health - Major Medical*	*Sub-TOI:*	*H16G.002A Large Group Only - PPO*
Product Name:	*2010 CSI*		
Project Name/Number:	*/*		

Correspondence Summary

Dispositions

Status	Created By	Created On	Date Submitted
Approved-Closed	Rosalind Minor	04/12/2010	04/12/2010

Filing Notes

Subject	Note Type	Created By	Created On	Date Submitted
Additional Fee	Note To Reviewer	Dewey Post	04/12/2010	04/12/2010
Additional Filing Fees	Note To Filer	Rosalind Minor	04/09/2010	04/09/2010

SERFF Tracking Number:	*CCGH-126577402*	*State:*	*Arkansas*
Filing Company:	*Connecticut General Life Insurance Company*	*State Tracking Number:*	*45392*
Company Tracking Number:			
TOI:	*H16G Group Health - Major Medical*	*Sub-TOI:*	*H16G.002A Large Group Only - PPO*
Product Name:	*2010 CSI*		
Project Name/Number:	*/*		

Disposition

Disposition Date: 04/12/2010
Implementation Date:
Status: Approved-Closed
Comment:

Rate data does NOT apply to filing.

SERFF Tracking Number:	*CCGH-126577402*	*State:*	*Arkansas*
Filing Company:	*Connecticut General Life Insurance Company*	*State Tracking Number:*	*45392*
Company Tracking Number:			
TOI:	*H16G Group Health - Major Medical*	*Sub-TOI:*	*H16G.002A Large Group Only - PPO*
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Schedule	Schedule Item	Schedule Item Status	Public Access
Supporting Document	Flesch Certification	Approved-Closed	Yes
Supporting Document	Application	Approved-Closed	Yes
Supporting Document	Forms Listing	Approved-Closed	Yes
Supporting Document	Variability Statement	Approved-Closed	Yes
Form	Enteral Nutrition	Approved-Closed	Yes
Form	Exclusions	Approved-Closed	Yes
Form	Short term Chiro	Approved-Closed	Yes
Form	Covered Expenses	Approved-Closed	Yes
Form	Accident and Health provisions	Approved-Closed	Yes
Form	Definitions	Approved-Closed	Yes
Form	In and Out of Network Schedule	Approved-Closed	Yes
Form	In Network only Schedule	Approved-Closed	Yes
Form	Prescription Drug Benefits Schedule 1	Approved-Closed	Yes
Form	Prescription Drug Benefits Schedule 4 Tier 1	Approved-Closed	Yes
Form	Prescription Drug Benefits Schedule 3	Approved-Closed	Yes
Form	Prescription Drug Benefits Schedule 2	Approved-Closed	Yes
Form	RX Covered Expenses	Approved-Closed	Yes
Form	RX Exclusions	Approved-Closed	Yes
Form	Definition of Preventive Medication	Approved-Closed	Yes
Form	Definition of Specialty Medication	Approved-Closed	Yes

SERFF Tracking Number:	*CCGH-126577402*	*State:*	*Arkansas*
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TOI:	*H16G Group Health - Major Medical*	*Sub-TOI:*	*H16G.002A Large Group Only - PPO*
Product Name:	*2010 CSI*		
Project Name/Number:	*/*		

Note To Reviewer

Created By:

Dewey Post on 04/12/2010 08:58 AM

Last Edited By:

Rosalind Minor

Submitted On:

04/12/2010 03:07 PM

Subject:

Additional Fee

Comments:

I have sent the additional $750, sorry for any inconvenience this may have caused.

SERFF Tracking Number:	*CCGH-126577402*	*State:*	*Arkansas*
Filing Company:	*Connecticut General Life Insurance Company*	*State Tracking Number:*	*45392*
Company Tracking Number:			
TOI:	*H16G Group Health - Major Medical*	*Sub-TOI:*	*H16G.002A Large Group Only - PPO*
Product Name:	*2010 CSI*		
Project Name/Number:	*/*		

Note To Filer

Created By:
Rosalind Minor on 04/09/2010 02:57 PM
Last Edited By:
Rosalind Minor
Submitted On:
04/12/2010 03:07 PM
Subject:
Additional Filing Fees
Comments:

Our filing fees under Rule 57 has been updated. Please review the SERFF General Instructions for ArkansasLH and the revised Rule 57.

the new fee for this submission is $50.00 per form for a total of $800.00. Please submit an additional $750.00.

We will begin our review of this submission upon receipt of the additional fees.

SERFF Tracking Number:	*CCGH-126577402*	*State:*	*Arkansas*
Filing Company:	*Connecticut General Life Insurance Company*	*State Tracking Number:*	*45392*
Company Tracking Number:			
TOI:	*H16G Group Health - Major Medical*	*Sub-TOI:*	*H16G.002A Large Group Only - PPO*
Product Name:	*2010 CSI*		
Project Name/Number:	*/*		

Form Schedule

Lead Form Number:

Schedule Item Status	Form Number	Form Type	Form Name	Action	Action Specific Data	Readability	Attachment
Approved-Closed 04/12/2010	GM6000 INDEM289	Certificate Amendment, Insert Page, Endorsement or Rider	Enteral Nutrition	Initial			AR GM6000 INDEM289 (Enteral Nutrition).pdf
Approved-Closed 04/12/2010	GM6000 INDEM290	Certificate Amendment, Insert Page, Endorsement or Rider	Exclusions	Initial			GM6000 INDEM290 (Exclusions continued).pdf
Approved-Closed 04/12/2010	GM6000 INDEM291	Certificate Amendment, Insert Page, Endorsement or Rider	Short term Chiro	Initial			GM6000 INDEM291 (STR and Chiro).pdf
Approved-Closed 04/12/2010	GM6000 INDEM292	Certificate Amendment, Insert Page, Endorsement or Rider	Covered Expenses	Initial			GM6000 INDEM292 (Family Planning, Contraception, Acupuncture).pdf
Approved-Closed 04/12/2010	GM6000 CLA63	Certificate Amendment, Insert Page, Endorseme	Accident and Health provisions	Initial			GM6000 CLA63 (Accident and Health Provisions).pd

		nt or Rider				f
Approved-Closed 04/12/2010	GM6000 DFS2133	Certificate Amendment, Insert Page, Endorsement or Rider	Definitions	Initial		GM6000 DFS2133 (Average Contracted Rates).pdf
Approved-Closed 04/12/2010	GM6000 SCH182	Certificate Amendment, Insert Page, Endorsement or Rider	In and Out of Network Schedule	Initial		AR GM6000 SCH182 - IN+OON Sched Final.pdf
Approved-Closed 04/12/2010	GM6000 SCH183	Certificate Amendment, Insert Page, Endorsement or Rider	In Network only Schedule	Initial		AR GM6000 SCH183 - IN Only Schedule.pdf
Approved-Closed 04/12/2010	GM6000 SCH175	Certificate Amendment, Insert Page, Endorsement or Rider	Prescription Drug Benefits Schedule 1	Initial		GM6000 SCH175.pdf
Approved-Closed 04/12/2010	GM6000 SCH176	Certificate Amendment, Insert Page, Endorsement or Rider	Prescription Drug Benefits Schedule 4 Tier 1	Initial		AR GM6000 SCH176.pdf
Approved-Closed 04/12/2010	GM6000 SCH177	Certificate Amendment, Insert Page, Endorsement or Rider	Prescription Drug Benefits Schedule 3	Initial		AR GM6000 SCH177.pdf
Approved-	GM6000	Certificate	Prescription Drug	Initial		AR GM6000

SERFF Tracking Number:	*CCGH-126577402*		*State:*	*Arkansas*		
Filing Company:	*Connecticut General Life Insurance Company*		*State Tracking Number:*	*45392*		
Company Tracking Number:						
TOI:	*H16G Group Health - Major Medical*		*Sub-TOI:*	*H16G.002A Large Group Only - PPO*		
Product Name:	*2010 CSI*					
Project Name/Number:	*/*					
Closed 04/12/2010	SCH178	Amendment, Insert Page, Endorsement or Rider	Benefits Schedule 2			SCH178.pdf
Approved-Closed 04/12/2010	GM6000 PHARM136	Certificate Amendment, Insert Page, Endorsement or Rider	RX Covered Expenses	Initial		AR GM6000 PHARM136.pdf
Approved-Closed 04/12/2010	GM6000 PHARM137	Certificate Amendment, Insert Page, Endorsement or Rider	RX Exclusions	Initial		GM6000 PHARM137.pdf
Approved-Closed 04/12/2010	GM6000 DFS2025	Certificate Amendment, Insert Page, Endorsement or Rider	Definition of Preventive Medication	Initial		GM6000 DFS2025.pdf
Approved-Closed 04/12/2010	GM6000 DFS2050	Certificate Amendment, Insert Page, Endorsement or Rider	Definition of Specialty Medication	Initial		GM6000 DFS2050.pdf

[MEDICAL BENEFITS]

Covered Expenses (Continued)

Enteral Nutrition

Enteral nutrition means medical foods that are specially formulated for enteral feedings or oral consumption.

Coverage includes amino acid modified preparations, low protein modified food products and any other special dietary products and formulas prescribed under the direction of a Physician for the Medically Necessary treatment of phenylketonuria (PKU).

For other diagnosis not specified above, coverage for enteral nutrition and supplies required for enteral feedings is provided when all of the following conditions are met:

- It is necessary to sustain life or health.
- It is used in the treatment of, or in association with, a demonstrable disease, condition or disorder.
- It requires ongoing evaluation and management by a Physician.
- It is the sole source of nutrition or a significant percentage of daily caloric intake.

Coverage for enteral nutrition does not include:

- Regular grocery products that meet the nutritional needs of the patient (e.g. over-the-counter infant formulas such as Similac, Nutramigen and Enfamil); or
- Medical food products that:
  - are prescribed without a diagnosis requiring such foods;
  - are used for convenience purposes;
  - have no proven therapeutic benefit without an underlying disease, condition or disorder;
  - are used as a substitute for acceptable standard dietary intervention; or
  - are used exclusively for nutritional supplementation.

Exclusions, Expenses Not Covered and General Limitations (Continued)

Additional coverage limitations determined by plan or provider type are shown in the Schedule. Payment for the following is specifically excluded from this plan:

- [Care for health conditions that are required by state or local law to be treated in a public facility.
- Care required by state or federal law to be supplied by a public school system or school district.
- Care for military service disabilities treatable through governmental services if you are legally entitled to such treatment and facilities are reasonably available.
- Treatment of an illness or injury which is due to war, declared, or undeclared, riot or insurrection.
- Custodial care of a member whose health is stabilized and whose current condition is not expected to significantly or objectively improve or progress over a specified period of time. Custodial care does not seek a cure, can be provided in any setting and may be provided between periods of acute or inter-current health care needs. Custodial care includes any skilled or non skilled health services or personal comfort and convenience services which provide general maintenance, supportive, preventive and/or protective care. This includes assistance with, performance of, or supervision of: walking, transferring or positioning in bed and range of motion exercises; self administered medications; meal preparation and feeding by utensil, tube or gastronomy; oral hygiene, skin and nail care, toilet use, routine enemas; nasal oxygen applications, dressing changes, maintenance of in-dwelling bladder catheters, general maintenance of colostomy ilieostomy, gastronomy, tracheostomy and casts.
- Any unproven or investigational services and supplies, including all related services and supplies.

  Unproven or investigational services and supplies are medical, surgical, diagnostic, psychiatric, substance abuse or other health care technologies, treatments, procedures, drugs and biologics or devices that are determined by CG to be: Not demonstrated by the weight of existing peer-reviewed, evidence-based scientific literature to be safe and effective for treating or diagnosing the sickness, condition, injury or illness for which its use is proposed; or Not currently the subject of active investigation because prior investigations and/or studies failed to establish proven efficacy and/or safety; or Not approved by the U.S. Food and Drug Administration (FDA) or other appropriate regulatory agency to be lawfully marketed for the proposed use, except for accepted off-label use of drugs and biologics, consistent with CG policy; or Substantially confined to use in the research setting; or The subject of review or approval by an Institutional Review Board for the proposed use, except as specifically provided in the “Clinical Trials” benefit section; or The subject of an ongoing phase I, II or III clinical trial, except as specifically provided in the “Clinical Trials” benefit section.
- Cosmetic Surgery and Therapies. Cosmetic surgery or therapy is defined as surgery or therapy performed to improve or alter appearance or self-esteem or to treat psychological symptomatology or psychosocial complaints related to one’s appearance including Idiopathic Short Stature Syndrome. However, reconstructive surgery and therapy are covered as provided in the “Reconstructive Surgery” section of Covered Expenses.
- The following services are excluded from coverage regardless of clinical indications: Macromastia or Gynecomastia Surgeries; [Surgical treatment of varicose veins;] Abdominoplasty; Panniculectomy; Rhinoplasty; Blepharoplasty; Redundant skin surgery; Removal of skin tags; Acupressure; Craniosacral/cranial therapy; Dance therapy, movement therapy; Applied kinesiology; Rolfing; Prolotherapy; and Extracorporeal shock wave lithotripsy (ESWL) for musculoskeletal and orthopedic conditions[, except as may be covered under the “Reconstructive Surgery” benefit].
- Dental treatment of the teeth, gums or structures directly supporting the teeth, including dental X-rays, examinations, repairs, orthodontics, periodontics, casts, splints and services for dental malocclusion, for any condition. [However, facility charges and charges for general anesthesia or deep sedation which cannot be administered in a dental office are covered when medically necessary.] Charges made for services or supplies provided for or in connection with an accidental injury to sound natural teeth are [also] covered provided a continuous course of dental treatment is started within six months of an accident. Sound natural teeth are defined as natural teeth that are free of active clinical decay, have at least 50% bony support and are functional in the arch.
- Treatment of TMJ disorders and craniofacial muscle disorders are excluded.
- Aids, devices or other adaptive equipment that assist with non-verbal communications, including, but not limited to communication boards, pre-recorded speech devices, laptop computers, desktop computers, Personal Digital Assistants (PDAs), Braille typewriters, visual alert systems for the deaf and memory books.
- Enteral feedings, supplies and specially formulated medical foods that are prescribed and non prescribed, except as specifically provided in the “Enteral Nutrition” benefit.

- Charges made by a physician/practitioner for broken appointments, phone calls, email or internet evaluations unless otherwise specified in the covered services section of your document.
- Eyeglass lenses and frames and contact lenses (except for the first pair of contact lenses for treatment of keratoconus or post-cataract surgery).
- Expenses incurred outside the United States, other than expenses for Medically Necessary urgent or emergent care while temporarily traveling abroad.
- [Routine refractions,] eye exercises and surgical treatment for the correction of a refractive error, including radial keratotomy.
- Any services, supplies or equipment intended primarily to provide a safe environment, including, but not limited to: helmets, safety goggles/glasses, bed exit monitors, restraints, telephone alert systems, fire extinguishers, smoke/carbon monoxide detectors, fall detection systems, safety rails, fixtures to real property to create a safe surrounding, first aid kits, automatic external defibrillators.]

[MEDICAL BENEFITS]

Covered Expenses (Continued)

Short-Term Rehabilitative Therapy [and Chiropractic Care Services]

- charges made for Short-term Rehabilitative Therapy that is part of a rehabilitative program, including physical, speech, occupational, cognitive, osteopathic manipulative, [cardiac rehabilitation] and pulmonary rehabilitation therapy, when provided in the most medically appropriate setting. [Also included are services that are provided by a chiropractic Physician when provided in an outpatient setting. Services of a chiropractic Physician include the conservative management of acute neuromusculoskeletal conditions through manipulation and ancillary physiological treatment that is rendered to restore motion, reduce pain and improve function.]

The following limitations apply to Short-term Rehabilitative Therapy [and Chiropractic Care Services]:

- [To be covered all therapy services must be restorative in nature. Restorative Therapy services are services that are designed to restore levels of function that had previously existed but that have been lost as a result of Injury or Sickness. Restorative Therapy services do not include therapy designed to acquire levels of function that had not been previously achieved prior to the Injury or Sickness.
- Services are not covered if they are custodial, training, educational or developmental in nature.]
- Occupational therapy is provided only for purposes of enabling persons to perform the activities of daily living after an Injury or Sickness.

Short-term Rehabilitative Therapy [and Chiropractic Care] services that are not covered include but are not limited to:

- sensory integration therapy, group therapy; treatment of dyslexia; behavior modification or myofunctional therapy for dysfluency, such as stuttering or other involuntarily acted conditions [without evidence of an underlying medical condition or neurological disorder];
- treatment for functional articulation disorder such as correction of tongue thrust, lisp, [or] verbal apraxia [or swallowing dysfunction] that is not based on an underlying diagnosed medical condition or Injury;
- maintenance or preventive treatment consisting of routine, long term or non-Medically Necessary care provided to prevent recurrences or to maintain the patient's current status;

[The following are specifically excluded from Chiropractic Care Services:

- Services of a chiropractor which are not within his scope of practice, as defined by state law;
- Charges for care not provided in an office setting;
- Vitamin therapy.]

[Services that are provided by a chiropractic Physician are not covered. These services include the conservative management of acute neuromusculoskeletal conditions through manipulation and ancillary physiological treatment rendered to restore motion, reduce pain and improve function.]

[If multiple outpatient services are provided on the same day they constitute one visit.]

[A separate Copayment will apply to the services provided by each provider.]

[**Chiropractic Care Services**

Charges made for diagnostic and treatment services utilized in an office setting by chiropractic Physicians. Chiropractic treatment includes the conservative management of acute neuromusculoskeletal conditions through manipulation and ancillary physiological treatment rendered to specific joints to restore motion, reduce pain, and improve function. For these services you have direct access to qualified chiropractic Physicians.

[You do not need a referral from your Primary Care Physician.]

The following limitation[s] [apply] [applies] to Chiropractic Care Services:

- [To be covered, all therapy services must be restorative in nature. Restorative Therapy services are services that are designed to restore levels of function that had previously existed but that have been lost as a result of Injury or Sickness. Restorative Therapy services do not include therapy designed to acquire levels of function that had not been previously achieved prior to the Injury or Sickness.
- Services are not covered if they are considered custodial, training, developmental or educational in nature.]
- Occupational therapy is provided only for purposes of enabling persons to perform the activities of daily living after an Injury or Sickness.

[Chiropractic Care services that are not covered include, but are not limited to:]

- Services of a chiropractor which are not within his scope of practice, as defined by state law;
- Charges for care not provided in an office setting;
- Maintenance or preventive treatment consisting of routine, long term or non-Medically Necessary care provided to prevent recurrence or to maintain the patient's current status; [and]
- Vitamin therapy;
- [Massage therapy in the absence of other modalities.]]

[MEDICAL BENEFITS]

Covered Expenses (Continued)

- charges made for Family Planning, including medical history, physical exam, related laboratory tests, medical supervision in accordance with generally accepted medical practices, other medical services, information and counseling on contraception, [implanted/injected contraceptives,] tubal ligations, vasectomies, [elective abortions] and infertility testing.

  [Office visits, tests and counseling for Family Planning services are subject to the Preventive Care Maximum shown in the Schedule.]

- [charges made for contraceptives, other than oral contraceptives. Refer to the Prescription Drug Benefits section for information regarding coverage of oral contraceptives.]

- [Acupuncture treatment - charges made for acupuncture services involving the stimulation of specific anatomical locations on the skin through the penetration of fine needles, for the purpose of relieving pain or treating disease as medically necessary.]

Accident and Health Provisions

Timely Filing

CG will consider claims for coverage under our plans when proof of loss (a claim) is submitted within [one year (365 days)] [180 days for In-Network benefits and one year (365 days) for Out-of-Network benefits] after services are rendered. If services are rendered on consecutive days, such as for a hospital confinement, the limit will be counted from the last date of service. If claims are not submitted within [one year] [180 days for In-Network benefits and one year (365 days) for Out-of-Network benefits], the claim will not be considered valid and will be denied.

DEFINITIONS

Average Contracted Rates (ACR)

The Average Contracted Rate (ACR) for covered services provided by a non-network provider is based on the average contracted rates for network providers in the area in which the care is provided, as determined by CG.

The covered amount for each service or supply will be the lesser of:

- the fee usually charged by a provider, and
- the ACR for that service or supply.

You are fully responsible for any amount over the ACR in addition to any applicable copays, deductibles and coinsurance.

However, for the following services, the allowable covered expense is determined by usual and customary charge guidelines:

- Services provided by out-of-area providers.
- Services by an assistant surgeon when the surgery is performed by a network Doctor in a network Hospital.
- Services by an anesthesiologist when the surgery is performed in a network Hospital.
- Services of a radiologist or pathologist in a network Hospital.
- Services received in an emergency room or as an inpatient in a Hospital following Emergency Room Care until the Emergency Medical condition is stabilized.
- Ambulance services.

The usual and customary charge for each service or supply received will be the lesser of the fee usually charged by a provider and the fee usually charged by other providers in the same geographical area for these services and supplies.

[Medical Benefits] The Schedule (continued)		
BENEFIT HIGHLIGHTS	**IN-NETWORK** **This Plan will pay:**	**OUT-OF-NETWORK** **This plan will pay:**
Physician's Services		
Primary Care Physician's Office visit	[No charge after $[0-100] per office visit copay] [[50-100]% after plan deductible]	[30-80]%% after plan deductible [not to exceed $[20-1,000]
Specialty Care Physician's Office Visits Consultant and Referral Physician's Services	[No charge after $[0-150] Specialist per office visit copay] [[50-100]% after plan deductible]	[30-80]% after plan deductible [not to exceed $[20-1,000]
Surgery Performed In the Physician's Office	[No charge after the $[0-100] PCP or $[0-150] Specialist per office visit copay] [[50-100]% [after plan deductible]]	[30-80]% after plan deductible [not to exceed $[20-1,000]
Second Opinion Consultations (provided on a voluntary basis)	[No charge after the $[0-100] PCP or $[0-150] Specialist per office visit copay] [[50-100]% after plan deductible]	[30-80]% after plan deductible [not to exceed $[20-1,000]
Allergy Treatment/Injections	[No charge after either the $[0-100] PCP or $[0-150] Specialist per office visit copay or the actual charge, whichever is less] [[50-100]% after plan deductible]	[30-80]% after plan deductible [not to exceed $[20-1,000]
Allergy Serum (dispensed by the Physician in the office)	[No charge] [[50-100]% after plan deductible]	[30-80]% after plan deductible] [not to exceed $[20-1,000]

Note: The benefit differential level between services rendered In-Network and Out-of-Network shall not exceed 25% of the allowable charge for the service rendered.

[Medical Benefits] The Schedule (continued)		
BENEFIT HIGHLIGHTS	**IN-NETWORK** **This Plan will pay:**	**OUT-OF-NETWORK** **This plan will pay:**
[**Preventive Care** Routine Preventive Care (including immunizations) through age 18.	[No charge]	[No charge]
Adult Routine Preventive Care Well-Woman periodic physical exams, routine immunizations and injections (age 19 and up) [[Contract] [Calendar] Year Maximum: [$250-Unlimited]]	[No charge after the $[0-100] PCP or $[0-150] Specialist per office visit copay]; [No charge] [[50-100]% after plan deductible]	[No charge] [30-80]% after plan deductible]
[Adult Routine Preventive Care after [Contract] [Calendar] Year Maximum is reached	[50-100]%	[30-80]% after plan deductible]
Preventive X-ray and/or Lab Services	[No charge]	
Immunizations	[No charge]	[No charge]

Note: The benefit differential level between services rendered In-Network and Out-of-Network shall not exceed 25% of the allowable charge for the service rendered.

BENEFIT HIGHLIGHTS	IN-NETWORK This Plan will pay:	OUT-OF-NETWORK This Plan will pay:
Mammograms, PSA, PAP Smear [**Notes:** • Mammogram charges do not accumulate to the plan's Preventive Care dollar maximum, regardless of place of service. • PSA and Pap Smear charges, when billed by the physician's office, will be subject to the plan's Preventive Care dollar maximum. • PSA and Pap Smear charges, when billed by an independent diagnostic facility or outpatient hospital, do not accumulate to the plan's Preventive Care dollar maximum.] • [All Mammogram, PSA and Pap Smear charges, when billed as a preventive care related service, accumulate to the plan's Preventive Care dollar maximum, regardless of place of service.].		
Preventive Care Related Services (i.e. "routine" services)	[No charge] [No charge after plan deductible] [[50-100]%] [[50-100]% after plan deductible]	[No charge] [No charge after plan deductible] [[30-80]%] [[30-80]% after plan deductible]
[Diagnostic Related Services (i.e. "non-routine" services)	[No charge] [No charge after plan deductible] [[50-100]%] [[50-100]% after plan deductible if billed by an independent diagnostic facility or outpatient hospital] [[50-100]% after plan deductible]	[No charge] [No charge after plan deductible] [[50-80]%] [[50-80]% after plan deductible]
[Diagnostic Related Services (i.e. "non-routine" services)	Subject to the plan's x-ray & lab benefit; based on place of service	[Subject to the plan's x-ray & lab benefit; based on place of service]]

Note: The benefit differential level between services rendered In-Network and Out-of-Network shall not exceed 25% of the allowable charge for the service rendered.

BENEFIT HIGHLIGHTS	IN-NETWORK This Plan will pay:	OUT-OF-NETWORK This Plan will pay:
Inpatient Hospital – Facility Services	[$[0-750 per day copay [up to 3-Unlimited] copays per admission, then [50-100]% after plan deductible]	[$[0-1,500 per day copay [up to 3-Unlimited] copays per admission, then [30-80]% after plan deductible] [not to exceed $500-100,000]

Note: The benefit differential level between services rendered In-Network and Out-of-Network shall not exceed 25% of the allowable charge for the service rendered.

BENEFIT HIGHLIGHTS	IN-NETWORK This Plan will pay:	OUT-OF-NETWORK This Plan will pay:
[**Emergency and Urgent Care Services**		
Urgent Care Facility or Outpatient Facility	[No charge after $[0-250] per visit copay*] [No charge] [No charge after $[0-250] per visit copay* and plan deductible [[50-100]% after plan deductible] [* Waived if admitted]	[No charge after $[0-250] per visit copay*] [No charge] [No charge after $[0-250] per visit copay* and plan deductible [[50-100]% after plan deductible] [(except if not a true emergency, then [30-80]% after plan deductible)] [[30-80]% after plan deductible] [* Waived if admitted]
Ambulance	[No charge] [[50-100]% after plan deductible] [not to exceed $500-30,000]]	[No charge] [[50-100]% after plan deductible] [not to exceed $500-30,000]] [[50-100]% after plan deductible (except if not a true emergency, then [30-80]% after plan deductible)]

Note: The benefit differential level between services rendered In-Network and Out-of-Network shall not exceed 25% of the allowable charge for the service rendered.

BENEFIT HIGHLIGHTS	IN-NETWORK This Plan will pay:	OUT-OF-NETWORK This Plan will pay:
Inpatient Services at Other Health Care Facilities Includes Skilled Nursing Facility, Rehabilitation Hospital and Sub-Acute Facilities [Contract] [Calendar] Year Maximum: [30-Unlimited] days combined [No prior hospitalization required]	[No charge after plan deductible] [[50-100]% after plan deductible]	[30-80]% after plan deductible [not to exceed $0-1,000]

Note: The benefit differential level between services rendered In-Network and Out-of-Network shall not exceed 25% of the allowable charge for the service rendered.

BENEFIT HIGHLIGHTS	IN-NETWORK This Plan will pay:	OUT-OF-NETWORK This Plan will pay:
Outpatient Short-Term Rehabilitative Therapy		
• **Outpatient Physical Therapy** [[Contract] [Calendar] Year Maximum: [20-Unlimited visits] [$1,000-Unlimited]	[No charge after the $[0-150] Specialist per visit copay] [[50-100]% after plan deductible]	[[30-80]% after plan deductible] [not to exceed $0-1,000]
• **Outpatient Speech, Hearing and Occupational Therapy** [[Contract] [Calendar] Year Maximum: [20-Unlimited visits] [$1,000-Unlimited]	[No charge after the $[0-150] Specialist per visit copay] [[50-100]% after plan deductible]	[[30-80]% after plan deductible] [not to exceed $0-1,000]

Note: The benefit differential level between services rendered In-Network and Out-of-Network shall not exceed 25% of the allowable charge for the service rendered.

BENEFIT HIGHLIGHTS	IN-NETWORK This Plan will pay:	OUT-OF-NETWORK This Plan will pay:
[**Chiropractic Care Services** [Contract] [Calendar] Year Maximum: [[12-Unlimited] [visits] [days]] [$[500-Unlimited]]		
Physician's Office Visit	[No charge after the $[0-100] PCP or $[0-150] Specialist per visit copay] [[50-100]% after plan deductible]	[30-80]% after plan deductible [not to exceed $0-1,000]]

Note: The benefit differential level between services rendered In-Network and Out-of-Network shall not exceed 25% of the allowable charge for the service rendered.

BENEFIT HIGHLIGHTS	IN-NETWORK This Plan will pay:	OUT-OF-NETWORK This Plan will pay:
[**Home Health Care** [Contract] [Calendar] Year Maximum: [40-Unlimited] [days] [visits] (includes outpatient private nursing when approved as medically necessary)	[No charge] [[50-100]% after plan deductible]	[30-80]% after plan deductible] [not to exceed $0-1,000]

Note: The benefit differential level between services rendered In-Network and Out-of-Network shall not exceed 25% of the allowable charge for the service rendered.

BENEFIT HIGHLIGHTS	IN-NETWORK This Plan will pay:	OUT-OF-NETWORK This Plan will pay:
[**Hospice** Inpatient Services	[No charge after plan deductible] [[50-100]% after plan deductible]	[30-80]% after plan deductible
Outpatient Services (same coinsurance level as Home Health Care)	[No charge] [[50-100]% after plan deductible]	[30-80]% after plan deductible
[Lifetime Maximum: $[5,000-Unlimited]]		

Note: The benefit differential level between services rendered In-Network and Out-of-Network shall not exceed 25% of the allowable charge for the service rendered.

BENEFIT HIGHLIGHTS	IN-NETWORK This Plan will pay:	OUT-OF-NETWORK This Plan will pay:
[**Organ Transplants** Includes all medically appropriate, non-experimental transplants		
Physician's Office Visit	[No charge after the $[0-100] PCP or $[0-150] Specialist per office visit copay] [[50-100]% after plan deductible]	[30-80]% after plan deductible
Inpatient Facility	[100% at Lifesource center after $[0-3,000] per admission copay, otherwise [50-100]% after $[0-3,000] per admission copay and plan deductible] [[50-100]% after $[0-3,000] per admission copay and plan deductible] [100% at Lifesource center after plan deductible, otherwise [50-100]% after plan deductible] [[50-100]% after plan deductible]	[$[0-6,000] per admission deductible, then [30-80]% after plan deductible up to transplant maximum] [[30-80]% after plan deductible up to transplant maximum]
Physician's Services	[100% at Lifesource center, otherwise [50-100]% after plan deductible] [100% at Lifesource center after plan deductible, otherwise [50-100]% after plan deductible] [[50-100]% after plan deductible]	[30-80]% after plan deductible up to specific organ transplant maximum Heart - $150,000 Liver - $250,000 Bone Marrow - $130,000 Heart/Lung - $185,000 Lung - $185,000 Pancreas - $50,000 Kidney - $80,000 Kidney/Pancreas - $80,000
Lifetime Travel Maximum: $10,000 per transplant	No charge (only available when using Lifesource facility)	

Note: The benefit differential level between services rendered In-Network and Out-of-Network shall not exceed 25% of the allowable charge for the service rendered.

BENEFIT HIGHLIGHTS	IN-NETWORK This Plan will pay:	OUT-OF-NETWORK This Plan will pay:
[Durable Medical Equipment (including External Prosthetic Appliances) [In-Network [Contract] [Calendar] Year Maximum: $[500-50,000]] [Out-of-Network [Contract] [Calendar] Year Maximum: $[500-50,000]] [[Contract] [Calendar] Year Maximum: [$500-50,000] [In-Network Lifetime Maximum: $[3,000-Unlimited]] [Out-of-Network Lifetime Maximum: $[3,000-Unlimited]] [Lifetime Maximum: $[3,000-Unlimited]] [Note: Services do accumulate to the plan's out-of-pocket maximum.]	[50-100]% after plan deductible	[[30-80]% after plan deductible]]

Note: The benefit differential level between services rendered In-Network and Out-of-Network shall not exceed 25% of the allowable charge for the service rendered.

BENEFIT HIGHLIGHTS	IN-NETWORK This Plan will pay:	OUT-OF-NETWORK This Plan will pay:
[**TMJ Surgical and Non-surgical** Always excludes appliances and orthodontic treatment. Subject to medical necessity.		
Physician's Office Visit	[No charge after the $[0-100] PCP or $[0-150] Specialist per office visit copay] [[50-100]% after plan deductible]	[[30-80]% after plan deductible]
Inpatient Facility	[No charge after $[0-3,000] per admission copay and plan deductible] [$[0-3,000] per admission copay, then [50-100]% after plan deductible] [[50-100]% after plan deductible]	[$[0-6,000] per admission deductible, then [30-80]% after plan deductible] [[30-80]% after plan deductible]
Outpatient Facility	[No charge after $[0-1,500] per visit copay and plan deductible] [$[0-1,500] per visit copay, then [50-100]% after plan deductible] [[50-100]% after plan deductible]	[$[0-6,000] per visit deductible, then [30-80]% after plan deductible] [[30-80]% after plan deductible]
Physician's Services	[No charge] [[50-100]% after plan deductible]	[[30-80]% after plan deductible]
[**Surgical and**] **Non surgical TMJ Services** [(surgical services will be covered same as any other illness)] [Lifetime Maximum: $[600-Unlimited]] [[Calendar] [Contract] Year Maximum: $1,000-Unlimited]]		

Note: The benefit differential level between services rendered In-Network and Out-of-Network shall not exceed 25% of the allowable charge for the service rendered.

BENEFIT HIGHLIGHTS	IN-NETWORK This Plan will pay:	OUT-OF-NETWORK This Plan will pay:
[**Acupuncture** Self-referred, Medically Necessary treatment of pain or disease by acupuncture provided on an outpatient basis, limited to a [5-Unlimited] [day] [visit] maximum per person per year	[No charge after the $[0-150] Specialist per office visit copay] [[50-100]% after plan deductible]	[In-Network coverage only] [[30-80]% after plan deductible]]

Note: The benefit differential level between services rendered In-Network and Out-of-Network shall not exceed 25% of the allowable charge for the service rendered.

[Medical Benefits] The Schedule (continued)	
BENEFIT HIGHLIGHTS	**This Plan will pay:**
[**Preventive Care** Routine Preventive Care (including immunizations) through age 18.	[No charge]
Adult Routine Preventive Care Well-Woman periodic physical exams, routine immunizations and injections (age 19 and up) [[Contract] [Calendar] Year Maximum: [$250-Unlimited]]	[No charge after the $[0-100] PCP or $[0-150] Specialist per office visit copay] [No charge] [[50-100]% after plan deductible]
[Adult Routine Preventive Care after [Contract] [Calendar] Year Maximum is reached	[50-100]%
Preventive X-ray and/or Lab Services	[50-100]% [after plan deductible]
Immunizations	[No charge]

BENEFIT HIGHLIGHTS	This Plan will pay:
Mammograms, PSA, PAP Smear [**Notes:** • Mammogram charges do not accumulate to the plan's Preventive Care dollar maximum, regardless of place of service. • PSA and Pap Smear charges, when billed by the physician's office, will be subject to the plan's Preventive Care dollar maximum. • PSA and Pap Smear charges, when billed by an independent diagnostic facility or outpatient hospital, do not accumulate to the plan's Preventive Care dollar maximum.] • [All Mammogram, PSA and Pap Smear charges, when billed as a preventive care related service, accumulate to the plan's Preventive Care dollar maximum, regardless of place of service.].	
Preventive Care Related Services (i.e. "routine" services)	[No charge] [No charge after plan deductible] [[50-100]%] [[50-100]% after plan deductible]
[Diagnostic Related Services (i.e. "non-routine" services)	[No charge] [No charge after plan deductible] [[50-100]%] [[50-100]% after plan deductible if billed by an independent diagnostic facility or outpatient hospital] [[50-100]% after plan deductible]
[Diagnostic Related Services (i.e. "non-routine" services)	Subject to the plan's x-ray & lab benefit; based on place of service

BENEFIT HIGHLIGHTS	This Plan will pay:
Inpatient Hospital – Facility Services	[$[0-750 per day copay [up to 3-Unlimited] copays per admission, then [50-100]% after plan deductible]

BENEFIT HIGHLIGHTS	This Plan will pay:
[**Emergency and Urgent Care Services**	
Urgent Care Facility or Outpatient Facility	[No charge after $[0-250] per visit copay*] [No charge] [No charge after $[0-250] per visit copay* and plan deductible [[50-100]% after plan deductible] [* Waived if admitted]
Ambulance	[No charge] [[50-100]% after plan deductible] [not to exceed $500-30,000]]

BENEFIT HIGHLIGHTS	This Plan will pay:
Inpatient Services at Other Health Care Facilities Includes Skilled Nursing Facility, Rehabilitation Hospital and Sub-Acute Facilities [Contract] [Calendar] Year Maximum: [30-Unlimited] days combined [No prior hospitalization required]	[No charge after plan deductible] [[50-100]% after plan deductible]

BENEFIT HIGHLIGHTS	This Plan will pay:
Outpatient Short-Term Rehabilitative Therapy	
• **Outpatient Physical Therapy** [[Contract] [Calendar] Year Maximum: [20-Unlimited visits] [$1,000-Unlimited]	[No charge after the $[0-150] Specialist per visit copay] [[50-100]% after plan deductible]
• **Outpatient Speech, Hearing and Occupational Therapy** [[Contract] [Calendar] Year Maximum: [20-Unlimited visits] [$1,000-Unlimited]	[No charge after the $[0-150] Specialist per visit copay] [[50-100]% after plan deductible]

BENEFIT HIGHLIGHTS	This Plan will pay:
[**Chiropractic Care Services** [Contract] [Calendar] Year Maximum: [[12-Unlimited] [visits] [days]] [$[500-Unlimited]]	
Physician's Office Visit	[No charge after the $[0-100] PCP or $[0-150] Specialist per visit copay] [[50-100]% after plan deductible]

BENEFIT HIGHLIGHTS	This Plan will pay:
[**Hospice** Inpatient Services	[No charge after plan deductible] [[50-100]% after plan deductible]
Outpatient Services (same coinsurance level as Home Health Care)	[No charge] [[50-100]% after plan deductible]
[Lifetime Maximum: $5,000-100,000]	

BENEFIT HIGHLIGHTS	This Plan will pay:
[**Organ Transplants** Includes all medically appropriate, non-experimental transplants	
Physician's Office Visit	[No charge after the $[0-100] PCP or $[0-150] Specialist per office visit copay] [[50-100]% after plan deductible]
Inpatient Facility	[100% at Lifesource center after $[0-3,000] per admission copay, otherwise [50-100]% after $[0-3,000] per admission copay and plan deductible] [[50-100]% after $[0-3,000] per admission copay and plan deductible] [100% at Lifesource center after plan deductible, otherwise [50-100]% after plan deductible] [[50-100]% after plan deductible]
Physician's Services	[100% at Lifesource center, otherwise [50-100]% after plan deductible] [100% at Lifesource center after plan deductible, otherwise [50-100]% after plan deductible] [[50-100]% after plan deductible]
Lifetime Travel Maximum: $10,000 per transplant	No charge (only available when using Lifesource facility)

BENEFIT HIGHLIGHTS	This Plan will pay:
[Durable Medical Equipment (including External Prosthetic Appliances) [In-Network [Contract] [Calendar] Year Maximum: $[500-50,000]] [Out-of-Network [Contract] [Calendar] Year Maximum: $[500-50,000]] [[Contract] [Calendar] Year Maximum: [$500-50,000] [In-Network Lifetime Maximum: $[3,000-Unlimited]] [Out-of-Network Lifetime Maximum: $[3,000-Unlimited]] [Lifetime Maximum: $[3,000-Unlimited]] [Note: Services do accumulate to the plan's out-of-pocket maximum.]	[50-100]% after plan deductible

BENEFIT HIGHLIGHTS	This Plan will pay:
[**TMJ Surgical and Non-surgical** Always excludes appliances and orthodontic treatment. Subject to medical necessity.	
Physician's Office Visit	[No charge after the $[0-100] PCP or $[0-150] Specialist per office visit copay] [[50-100]% after plan deductible]
Inpatient Facility	[No charge after $[0-3,000] per admission copay and plan deductible] [$[0-3,000] per admission copay, then [50-100]% after plan deductible] [[50-100]% after plan deductible]
Outpatient Facility	[No charge after $[0-1,500] per visit copay and plan deductible] [$[0-1,500] per visit copay, then [50-100]% after plan deductible] [[50-100]% after plan deductible]
Physician's Services	[No charge] [[50-100]% after plan deductible]
[**Surgical and**] **Non surgical TMJ Services** [(surgical services will be covered same as any other illness)] [Lifetime Maximum: $[600-Unlimited]] [[Calendar] [Contract] Year Maximum: $1,000-Unlimited]]	

BENEFIT HIGHLIGHTS	This Plan will pay:
[**Acupuncture** Self-referred, Medically Necessary treatment of pain or disease by acupuncture provided on an outpatient basis, limited to a [5-Unlimited] [day] [visit] maximum per person per year	[No charge after the $[0-150] Specialist per office visit copay] [[50-100]% after plan deductible]

PRESCRIPTION DRUG BENEFITS
THE SCHEDULE

For You and Your Dependents

This plan provides Prescription Drug benefits for Prescription Drugs and Related Supplies provided by Pharmacies as shown in this Schedule.

To receive Prescription Drug Benefits, you and your Dependents may be required to pay a portion of the Covered Expenses for Prescription Drugs and Related Supplies. That portion includes any applicable Copayment, Deductible and/or Coinsurance.

(Use when 90-Day supply is provided for the Retail Pharmacy Network.)

[Certain retail Participating Pharmacies can fill your prescription [excluding Specialty Medication] for an [80-90]-day supply [for an amount equal to3x the retail Participating Pharmacy Copayment][at the same Copayment or Coinsurance that applies to mail order Participating Pharmacy Prescription Drugs][after you have filled a 30-day prescription for the same medication.].

Please see our website at [www.CIGNA.com][www.myCIGNAforhealth.com] or call the Member Services number on your ID card for a list of retail Participating Pharmacies that offer the [3x retail Participating Pharmacy Copayment level.].[the mail order Participating Pharmacy Copayment or Coinsurance level.]

(Add text when member pays 100% of the discounted cost for non-preferred brand drugs, or drugs not covered under the plan.)

[You and your Dependents will pay 100% of CG's discounted cost at a Participating Pharmacy for:]

- [Brand-Name* drugs on the Prescription Drug List with a Generic equivalent and drugs designated as non-preferred on the Prescription Drug List.]
- [Prescription Drugs and Related Supplies that are not Covered Expenses under this plan.]

(Include if Deductible is included and vary as shown.)

[Brand-Name][Deductible	
Individual Deductible	$0-$700
Family Deductible	$0-$2,100]

(4 TIER)

PRESCRIPTION DRUG BENEFITS

THE SCHEDULE-

BENEFIT HIGHLIGHTS	**PARTICIPATING PHARMACY**	**NON-PARTICIPATING PHARMACY**
[Lifetime Maximum-]	[Refer to the Medical Benefits Schedule]	[Refer to the Medical Benefits Schedule]
Retail Prescription Drugs	**The amount you pay for each 30-day supply**	**The amount you pay for each 30-day supply**
Tier 1 **Generic*Drugs designated as Preventive Medication on the Prescription Drug List**	***(Use for copay plans)*** [No charge after 0- $30] ***(Use for coinsurance plans)*** [0-50 %] ***(Add with Min/Max)*** [subject to [a minimum of 0- $30] [and] [a maximum of 0- $30] then the plan pays 100%]	[0-70%]
Tier 2 **Generic Drugs that are not designated as Preventive Medication on the Prescription Drug List**	***(Use for copay plans)*** [No charge after 0- $60] ***(Use for coinsurance plans)*** [0-50 %] ***(Add with Min/Max)*** [subject to [a minimum of 0- $60] [and] [a maximum of 0- $60] then the plan pays 100%]	[0-70 %]
Tier 3 **Brand-Name* drugs designated as preferred on the Prescription Drug List with no Generic equivalent**	***(Use for copay plans)*** [No charge after 0- $100] ***(Use for coinsurance plans)*** [0-70 %] ***(Add with Min/Max)*** [subject to [a minimum of 0- $100] [and] [a maximum of 0- $100] then the plan pays 100%]	[0-70]
[Tier 4 **Specialty Medication]**	***(Use for copay plans)*** [No charge after 0- $110] ***(Use for coinsurance plans)*** [0-90 %] ***(Add with Min/Max)*** [subject to [a minimum of 0- $110] [and] [a maximum of 0- $170]then the plan pays 100%] ***(Use for Retail Lock-out)*** [100% of CG's discounted cost after the first fill of Specialty Medication]	[0-70 %]

*Designated as per generally-accepted industry sources and adopted by CG

(4 TIER)
PRESCRIPTION DRUG BENEFITS
THE SCHEDULE-

BENEFIT HIGHLIGHTS	**PARTICIPATING PHARMACY**	**NON-PARTICIPATING PHARMACY**
(include text that follows if mail order coverage is elected.)		
[Mail Order Drugs]	**The amount you pay for each 90-day supply**	**The amount you pay for each 90-day supply**
[Tier 1 **Generic*Drugs designated as Preventive Medication on the Prescription Drug List]**	***(Use for copay plans)*** [No charge after 0- $90] ***(Use for coinsurance plans)*** [0-50%] ***(Add with Min/Max)*** [subject to [a minimum of 0- $90] [and][a maximum of 0- $90] then the plan pays 100%]	[0-70%]
[Tier 2 **Generic Drugs that are not designated as Preventive Medication on the Prescription Drug List]**	***(Use for copay plans)*** [No charge after 0- $180] ***(Use for coinsurance plans)*** [0-50%] ***(Add with Min/Max)*** [subject to [a minimum of 0- $180] [and] [a maximum of 0- $180]then the plan pays 100%]	[0-70%]
[Tier 3 **Brand-Name* drugs designated as preferred on the Prescription Drug List with no Generic equivalent]**	***(Use for copay plans)*** [No charge after 0- $300] ***(Use for coinsurance plans)*** [0-70%] ***(Add with Min/Max)*** [subject to [a minimum of 0- $300] [and] [a maximum of 0- $300]then the plan pays 100%]	[0-70%]
[Tier 4 **Specialty Medication]**	**(*add with 30-day supply for specialty medications)*** [Specialty Medications are limited to a 30-day supply and are subject to the same Copayment or Coinsurance that applies to retail Participating Pharmacies.] ***(Use for copay plans)*** [No charge after 0- $330] ***(Use for coinsurance plans)*** [0-90%] ***(Add with Min/Max)*** [subject to [a minimum of 0- $330] [and] [a maximum of 0- $510] then the plan pays 100%]	[0-70%]

*Designated as per generally-accepted industry sources and adopted by CG

(4 TIER)

PRESCRIPTION DRUG BENEFITS

THE SCHEDULE-

BENEFIT HIGHLIGHTS	**PARTICIPATING PHARMACY**	**NON-PARTICIPATING PHARMACY**
[Lifetime Maximum-]	[Refer to the Medical Benefits Schedule]	[Refer to the Medical Benefits Schedule]
Retail Prescription Drugs	**The amount you pay for each 30-day supply**	**The amount you pay for each 30-day supply**
Tier 1 **Generic*Drugs designated as Preventive Medication on the Prescription Drug List**	***(Use for copay plans)*** [No charge after 0- $30] ***(Use for coinsurance plans)*** [0-50 %] ***(Add with Min/Max)*** [subject to [a minimum of 0- $30] [and] [a maximum of 0- $30] then the plan pays 100%]	[0-70 %]
Tier 2 **Generic Drugs not designated as Preventive Medication on the Prescription Drug List and Brand-Name* drugs designated as preferred on the Prescription Drug List with no Generic equivalent**	***(Use for copay plans)*** [No charge after 0- $60] ***(Use for coinsurance plans)*** [0-50 %] ***(Add with Min/Max)*** [subject to [a minimum of 0- $60] [and] [a maximum of 0- $60] then the plan pays 100%]	[0-70 %]
Tier 3 **Brand-Name * drugs with a Generic equivalent and drugs designated as non-preferred on the Prescription Drug List**	***(Use for copay plans)*** [No charge after 0- $100] ***(Use for coinsurance plans)*** [0-70%] ***(Add with Min/Max)*** [subject to [a minimum of 0- $100] [and] [a maximum of 0- $100] then the plan pays 100%]	[0-70 %]
[Tier 4 **Specialty Medication]**	***(Use for copay plans)*** [No charge after 0- $110] ***(Use for coinsurance plans)*** [0-90 %] ***(Add with Min/Max)*** [subject to [a minimum of 0- $110] [and] [a maximum of 0- $150]then the plan pays 100%] ***(Use for Retail Lock-out)*** [100% of CG's discounted cost after the first fill of Specialty Medication]	[0-70 %]

*Designated as per generally-accepted industry sources and adopted by CG

(4 TIER)
PRESCRIPTION DRUG BENEFITS
THE SCHEDULE-

BENEFIT HIGHLIGHTS	**PARTICIPATING PHARMACY**	**NON-PARTICIPATING PHARMACY**
(include text that follows if mail order is covered) **[Mail Order Drugs]**	**The amount you pay for each 90-day supply**	**The amount you pay for each 90-day supply**
[Tier 1 **Generic*Drugs designated as Preventive Medication on the Prescription Drug List]**	***(Use for copay plans)*** [No charge after 0- $90] ***(Use for coinsurance plans)*** [0-50%] ***(Add with Min/Max)*** [subject to [a minimum of 0- $90] [and] [a maximum of 0- $90 then the plan pays 100%]	[0-70%]
[Tier 2 **Generic Drugs not designated as Preventive Medication on the Prescription Drug List and Brand-Name* drugs designated as preferred on the Prescription Drug List with no Generic equivalent]**	***(Use for copay plans)*** [No charge after 0- $180] ***(Use for coinsurance plans)*** [0-50%] ***(Add with Min/Max)*** [subject to [a minimum of 0- $180] [and] [a maximum of 0- $180 then the plan pays 100%]	[0-70%]
[Tier 3 **Brand-Name* drugs with a Generic equivalent and drugs designated as non-preferred on the Prescription Drug List]**	***(Use for copay plans)*** [No charge after 0- $300] ***(Use for coinsurance plans)*** [0-70%] ***(Add with Min/Max)*** [subject to [a minimum of 0- $300] [and] [a maximum of 0- $300 then the plan pays 100%]	[0-70%]
[Tier 4 **Specialty Medication]**	**(*add with 30-day supply for specialty medications)*** [Specialty Medications are limited to a 30-day supply and are subject to the same Copayment or Coinsurance that applies to retail Participating Pharmacies.] ***(Use for copay plans)*** [No charge after 0- $330] ***(Use for coinsurance plans)*** [0-90%] ***(Add with Min/Max)*** [subject to [a minimum of 0- $330] [and] [a maximum of 0- $450] then the plan pays 100%]	[0-70%]

*Designated as per generally-accepted industry sources and adopted by CG

(3 TIER with options for separate specialty and flat coinsurance)

PRESCRIPTION DRUG BENEFITS

THE SCHEDULE

BENEFIT HIGHLIGHTS	**PARTICIPATING PHARMACY**	**NON-PARTICIPATING PHARMACY**
[Lifetime Maximum-]	[Refer to the Medical Benefits Schedule]	[Refer to the Medical Benefits Schedule]
(Option1) ***(Include text below for plans with tiers 1-3. Vary to include an option for a separate specialty benefit.)***		
[Retail Prescription Drugs]	**The amount you pay for each 30-day supply**	**The amount you pay for each 30-day supply**
[Tier 1 **Generic*Drugs on the Prescription Drug List]**	***(Use for copay plans)*** [No charge after 0- $30] ***(Use for coinsurance plans)*** [0-50 %] ***(Add with Min/Max)*** [subject to [a minimum of 0- $30] [and] [a maximum of 0- $30] then the plan pays 100%] ***(Use for Retail Lock-out)*** [100% of CG's discounted cost after the first fill of Specialty Medication]	[0-70 %]
[Tier 2 **Brand-Name* drugs designated as preferred on the Prescription Drug List with no Generic equivalent]**	***(Use for copay plans)*** [No charge after 0- $60] ***(Use for coinsurance plans)*** [0-50 %] ***(Add with Min/Max)*** [subject to [a minimum of 0- $60] [and] [a maximum of 0- $60] then the plan pays 100%] ***(Use for Retail Lock-out)*** [100% of CG's discounted cost after the first fill of Specialty Medication]	[0-70 %]

*Designated as per generally-accepted industry sources and adopted by CG

(3 TIER with options for separate specialty and flat coinsurance)

PRESCRIPTION DRUG BENEFITS
THE SCHEDULE

BENEFIT HIGHLIGHTS	**PARTICIPATING PHARMACY**	**NON-PARTICIPATING PHARMACY**
[Tier 3 **Brand-Name * drugs with a Generic equivalent and drugs designated as non-preferred on the Prescription Drug List]**	***(Use for copay plans)*** [No charge after 0- $120] ***(Use for coinsurance plans)*** [0-70 %] ***(Add with Min/Max)*** [subject to [a minimum of 0- $120] [and] [a maximum of 0- $120] then the plan pays 100%] ***(Use for Retail Lock-out)*** [100% of CG's discounted cost after the first fill of Specialty Medication]	[0-70 %]
(Include separate specialty benefit text if specialty medications are not covered in tiers 1-3) **[Specialty Medication]**	***(Use for copay plans)*** [No charge after 0- $130] ***(Use for coinsurance plans)*** [0-90 %] ***(Add with Min/Max)*** [subject to [a minimum of 0- $130] [and] [a maximum of 0- $170]then the plan pays 100%] ***(Use for Retail Lock-out)*** [100% of CG's discounted cost after the first fill of Specialty Medication]	[0-70 %]
(Option 2 -Include text below for flat coinsurance plans.		
[Retail Prescription Drugs]	[0-50 %]	[0-70 %]

*Designated as per generally-accepted industry sources and adopted by CG

(3 TIER with options for separate specialty and flat coinsurance)

PRESCRIPTION DRUG BENEFITS
THE SCHEDULE

BENEFIT HIGHLIGHTS	**PARTICIPATING PHARMACY**	**NON-PARTICIPATING PHARMACY**
(Option1-include text below if mail order coverage is elected for plans with tiers 1-3. Vary to include an option for a separate specialty benefit)		
[Mail Order Drugs]	**The amount you pay for each 90-day supply**	**The amount you pay for each 90-day supply**
[Tier 1 **Generic*Drugs on the Prescription Drug List]**	***(Use with 30 day supply for Specialty Medications)*** [Specialty Medications are limited to a 30-day supply and are subject to the same Copayment or Coinsurance that applies to retail Participating Pharmacies.] ***(Use for copay plans)*** [No charge after 0- $90] ***(Use for coinsurance plans)*** [0-50%] ***(Add with Min/Max)*** [subject to a minimum of 0- $90 and a maximum of 0- $90 then the plan pays 100%]	[0-70%]
[Tier 2 **Brand-Name * drugs designated as preferred on the Prescription Drug List with no Generic equivalent]**	***(Use with 30 day supply for Specialty Medications)*** [Specialty Medications are limited to a 30-day supply and are subject to the same Copayment or Coinsurance that applies to retail Participating Pharmacies.] ***(Use for copay plans)*** [No charge after 0- $180] ***(Use for coinsurance plans)*** [0-50%] ***(Add with Min/Max)*** [subject to a minimum of 0- $180 and a maximum of 0- $180 then the plan pays 100%]	[0-70%]

*Designated as per generally-accepted industry sources and adopted by CG

(3 TIER with options for separate specialty and flat coinsurance)

PRESCRIPTION DRUG BENEFITS
THE SCHEDULE

BENEFIT HIGHLIGHTS	**PARTICIPATING PHARMACY**	**NON-PARTICIPATING PHARMACY**
[Tier 3 Brand-Name * drugs with a Generic equivalent and drugs designated as non-preferred on the Prescription Drug List]	***(Use with 30 day supply for Specialty Medications)*** [Specialty Medications are limited to a 30-day supply and are subject to the same Copayment or Coinsurance that applies to retail Participating Pharmacies.] ***(Use for copay plans)*** [No charge after 0- $360] ***(Use for coinsurance plans)*** [0-70%] ***(Add with Min/Max)*** [subject to[a minimum of 0- $360] [and] [a maximum of 0- $360] then the plan pays 100%]	[0-70%]
(Include separate specialty benefit text if specialty medications are not covered in tiers 1-3) **[Specialty Medication]**	***(Use with 30 day supply for Specialty Medications)*** [Specialty Medications are limited to a 30-day supply and are subject to the same Copayment or Coinsurance that applies to retail Participating Pharmacies.] ***(Use for copay plans)*** [No charge after 0- $390] ***(Use for coinsurance plans)*** [0-90%] ***(Add with Min/Max)*** [subject to [a minimum of 0- $390] [and] [a maximum of 0- $510] then the plan pays 100%]	[0-70%]
(Option 2 -Include text below for flat coinsurance plans.)		
[Mail Order Drugs]	[0-50 %]	[0-70 %]

*Designated as per generally-accepted industry sources and adopted by CG

PRESCRIPTION DRUG BENEFITS

For You and Your Dependents

Covered Expenses

If you or any one of your Dependents, while insured for Prescription Drug Benefits, incurs expenses for charges made by a Pharmacy, for Medically Necessary Prescription Drugs or Related Supplies ordered by a Physician, CG will provide coverage for those expenses as shown in the Schedule. Coverage also includes Medically Necessary Prescription Drugs and Related Supplies dispensed for a prescription issued to you or your Dependents by a licensed dentist for the prevention of infection or pain in conjunction with a dental procedure.

When you or a Dependent is issued a prescription for Medically Necessary Prescription Drugs or Related Supplies as part of the rendering of Emergency Services and that prescription cannot reasonably be filled by a Participating Pharmacy, the prescription will be covered by CG, as if filled by a Participating Pharmacy.

Limitations

Each Prescription Order or refill shall be limited as follows:

(Include text that follows for plans without 365 day supply limit.)

- [up to a consecutive 30-day supply, at a retail Pharmacy unless limited by the drug manufacturer's packaging: or]

(Add text if mail-order pharmacy coverage is included. If Specialty Medication is not available in a 90 day supply, add text in the first bullet and add the 2nd bullet with the 30-day supply limit text.)

- [up to a consecutive 90-day supply [excluding Specialty Medications] at a mail-order Pharmacy, unless limited by the drug manufacturer's packaging; or]
- [up to a consecutive 30-day supply for Specialty Medications at a mail order Pharmacy unless limited by the drug manufacturer's packaging; or.]

(Add next bullet if plan includes the retail lock-out benefit.)

- [to one fill of Specialty Medication at a retail Pharmacy. If you exceed the one fill allowed at a retail Pharmacy, you will be required to pay 100% of CG's discounted cost.]
- [to a dosage and/or dispensing limit as determined by the P&T Committee;]

PRESCRIPTION DRUG BENEFITS

(Include text that follows for plans with 365 day supply limit.)

(If Specialty Medication is not available in a 365 day supply, add text in the first bullet.)

- [up to a consecutive 365-day supply,[excluding Specialty Medications] at a Pharmacy unless limited by the drug manufacturer's packaging: or]
- [up to a consecutive 30-day supply for Specialty Medications at a retail Pharmacy or a 90-day supply at a mail order Pharmacy unless limited by the drug manufacturer's packaging; or.]
- [to a dosage and/or dispensing limit as determined by the P&T Committee;]

PRESCRIPTION DRUG BENEFITS

(Exclusions may be varied to be included or omitted)

[Exclusions

No payment will be made for the following expenses:

- human growth hormones.
- anabolic steroids.
- Brand-Name* drugs on the Prescription Drug List with a Generic equivalent and drugs designated as non-preferred on the Prescription Drug List
- pre-filled insulin pens and cartridges.**]**

DEFINITIONS

(Definition may be included or excluded)

[Preventive Medication

The term Preventive Medication means prescription medications taken by a person who has developed risk factors for a disease that has not yet manifested itself or not yet become clinically apparent, or to prevent the reoccurrence of a disease from which a person has recovered. However, this does not include any drugs or medications used to treat an existing illness, injury or condition.]

.

(*Definition may be included or excluded*)

[Specialty Medication

The term Specialty Medication means high cost medications which are used to treat rare and chronic conditions which include, but are not limited to, multiple sclerosis, hepatitis C or rheumatoid arthritis.]

SERFF Tracking Number:	*CCGH-126577402*	*State:*	*Arkansas*
Filing Company:	*Connecticut General Life Insurance Company*	*State Tracking Number:*	*45392*
Company Tracking Number:			
TOI:	*H16G Group Health - Major Medical*	*Sub-TOI:*	*H16G.002A Large Group Only - PPO*
Product Name:	*2010 CSI*		
Project Name/Number:	*/*		

Supporting Document Schedules

		Item Status:	Status Date:
Satisfied - Item:	Flesch Certification	Approved-Closed	04/12/2010

Comments:

Attachment:

Generic Flesch.pdf

		Item Status:	Status Date:
Bypassed - Item:	Application	Approved-Closed	04/12/2010

Bypass Reason: N/A

Comments:

		Item Status:	Status Date:
Satisfied - Item:	Forms Listing	Approved-Closed	04/12/2010

Comments:

Attachment:

SERFF - Forms Listing _Medical and Rx_ - 03-26-10.pdf

		Item Status:	Status Date:
Satisfied - Item:	Variability Statement	Approved-Closed	04/12/2010

Comments:

Attachment:

SERFF - Statement of Variability _Medical and Rx_ - 03-16-….pdf

CONNECTICUT GENERAL LIFE INSURANCE COMPANY
Group Forms

This is to certify that the forms listed below are in compliance with state readability laws and regulations and the NAIC Life and Health Insurance Policy Language Simplification Model Act.

A. Option Selected

Certificate pages are scored as a group for the Flesch reading ease test.

Form and Form Numbers to Which Certification is Applicable:

Form	Form Number	Flesch Score
GM6000	INDEM289 et al.	45.63

B. Test Option Selected

Test was applied to certificate insert pages as a group.

C. Standards for Certification

The following standards have been achieved:

1. The text achieved the minimum score of 50 on the Flesch reading ease test in accordance with section A above.

2. It is printed in not less than ten point type, one point leaded. (This does not apply to specification pages, schedules and tables.)

3. The layout and spacing separate the paragraphs from each other and from the border of the paper.

4. The section titles are captioned in bold face type or otherwise stand out significantly from the text.

5. Unnecessarily long, complicated or obscure words, sentences, paragraphs, or constructions are not used.

6. The style, arrangement and overall appearance of the policy give no undue prominence to any portion of the policy or to any endorsements or riders.

7. A table of contents or an index of the principal sections is included in the policy.

8. Any words which are defined in the policy(ies) and any medical terminology have been excluded from the Flesch test score.

Edmund J. Skowronek, Jr.	Director	March 31, 2010
	Officer's Title	Date

GM6000 INDEM289	Medical Benefits – Covered Expenses (continued)
GM6000 INDEM290	Medical Benefits – Exclusions (continued)
GM6000 INDEM291	Medical Benefits – Covered Expenses (continued)
GM6000 INDEM292	Medical Benefits – Covered Expenses (continued)
GM6000 CLA63	Accident and Health Provisions
GM6000 DFS2133	Definitions: Average Contracted Rate
GM6000 SCH182	Medical Benefits Schedule: Plans with IN and OON Benefits
GM6000 SCH183	Medical Benefits Schedule: Plans with IN Benefits only or Comprehensive Medical Plans
GM6000 SCH175	Prescription Drug Benefits Schedule
GM6000 SCH176	Prescription Drug Benefits 4 tier Schedule
GM6000 SCH177	Prescription Drug Benefits 4 tier Schedule
GM6000 SCH178	Prescription Drug Benefits 3 tier Schedule
GM6000 PHARM136	Prescription Drug Benefits - Covered Expenses
GM6000 PHARM137	Prescription Drug Benefits - Exclusions
GM6000 DFS2025	Definition of Preventive Medication
GM6000 DFS2050	Definition of Specialty Medication

Connecticut General Life Insurance Company

Statement of Variability
Forms GM6000 INDEM289, et al.

1. To the extent that variable changes are made they will not be ambiguous or deceptive.

2. Titles or names such as the product name may change, but their relation to the matter to which they pertain will not be ambiguous or deceptive.

3. Connective words and phrases that only serve the grammatical purpose of meaningful continuity may vary as the sense demands.

4. Wording may vary in order to facilitate and/or to clarify the meaning of terms and benefits conveyed in the coverage. Examples of such changes include but are not limited to: benefit provisions may be rewritten at the request of a Policyholder to clarify the Policyholder's understanding of benefits and/or administration.

5. Schedule items may be varied to reflect Policyholder election (e.g. a "copay" cost sharing option is elected for a coverage item rather than a "coinsurance" cost-sharing option). Possible numerical values available to Policyholder's are expressed by a defined range in the Schedule (i.e., a copayment dollar amount range, a coinsurance percentage range, a day or visit maximum range or contract, calendar year or lifetime dollar maximum range). Policyholders may elect any numerical value within the identified range.

6. Proposed Exclusion text has been marked variable to allow a Policyholder to include all, or some, of the proposed exclusions.

7. Proposed Covered Expenses text has been marked variable to allow a Policyholder to include all, or some, of the proposed coverage items.

Forms GM6000 SCH175 et. al.

1. To the extent that variable changes are made they will not be ambiguous or deceptive.

2. Titles or names such as Product Name may change but their relation to the matter to which they pertain will not be ambiguous or deceptive.

3. Connective words and phrases that only serve the grammatical purpose of meaningful continuity may vary as the sense demands.

4. Wording may vary in order to facilitate and/or to clarify the meaning of terms and benefits conveyed in the coverage. Examples of such changes include but are not limited to: benefit provisions may be re-written at the request of our customers to clarify the policyholder's understanding of benefits and/or administration.

5. Wording will vary in accordance with the variable description in bold that precedes the variable text.